DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Office of Radiation Control

APPLICATION FOR RADIOGRAPHY CERTIFICATE
LIMITED SCOPE LICENSURE FOR DELAWARE RADIATION TECHNICIANS

Complete and return this application with a non-refundable/non-transferable application fee toward obtaining a radiography certificate. See below for specific examination fees. **Make check or money order payable to the State of Delaware** and mail to the following address. Note that cash will not be accepted, and incomplete applications will be returned. This application will expire six (6) months from the date of signature. Allow a minimum of three (3) weeks for processing.

Delaware Division of Public Health
Office of Radiation Control
417 Federal Street
Dover, DE 19901

(PLEASE TYPE OR PRINT LEGIBLY)

NAME: _____ DAYTIME PHONE: _____

EVENING PHONE: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP:_____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

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STATE EXAMINEES (LIMITED SCOPE: MEDICAL RADIATION TECHNICIANS

EXAMINATION FEE: $110.00 (includes $ 10 application fee) made payable to the State of Delaware.
(Your name, address, birth date and social security number will be sent to the American Registry of Radiologic Technologists (ARRT) for processing to determine exam date).

I plan to take the following examination(s), (please check all specialties that apply):

__**X**__ Core Medical Exam (required for all), plus ___ Chest ___ Extremities ___ Skull ___Spine ___ Podiatry

STATE EXAMINEES: BONE DENSITOMETRY RADIATION TECHNICIANS

EXAMINATION FEE: $110.00 (includes $ 10 application fee) made payable to the State of Delaware.
(Your name, address, birth date and social security number will be sent to the American Registry of Radiologic Technologists for processing to determine exam date).

____ Bone Densitometry Operators Exam (for those seeking to practice bone densitometry ONLY)

STATE EXAMINEES: DENTAL RADIATION TECHNICIANS

EXAMINATION FEE: $10.00 check or money order made payable to the State of Delaware. Upon submitting this form, you will be sent a DE Dental Exam application and Factsheet, and the Delaware Radiation Technician/Technologist Manual. Upon receiving this packet, you will schedule your examination and make payment directly with the examination provider (DANB).

Are you currently enrolled in a JRCERT* Approved Radiology Program? YES_____ NO _____
*JRCERT = Joint Review Committee on Education in Radiologic Technology/Therapy

Are you currently enrolled in a Vocational Dental Assisting Program? YES_____NO_____
If you checked yes, please write in name of your school _____

Have you been convicted of a felony within the past ten years? YES_____ NO _____ If yes, explain the circumstances on a separate sheet of paper and attach a photocopy of any relevant documentation related to how the felony conviction was resolved.
I certify that the information provided is true to the best of my knowledge.

_____ _____
APPLICANT'S SIGNATURE **DATE**